Uniform Medical Plan

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Chiropractor Fee Schedule (Most Commonly Billed Codes)

Effective 7/1/05

Last revised 5/27/05

The procedure codes and maximum allowances in this document do not necessarily indicate coverage or payment. All coverage and payments are subject to plan benefits, exclusions, limitations, and pre-authorization requirements. Please refer to the Uniform Medical Plan (UMP) *Billing and Administrative Manual for Professional Providers* and *Certificate of Coverage* for additional information.

The descriptions for the Current Procedural Terminology (CPT™) and Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) level II codes listed here are abbreviated. For billing purposes, please use the most recent edition of the CPT™ and HCPCS level II coding books which include complete descriptions of the codes.

Visit the UMP web site at www.ump.hca.wa.gov to download the latest versions of this fee schedule and all other UMP publications mentioned in this document.

Fees in this publication are subject to change without notice. Although we make every effort to ensure the accuracy of the fees in our publications, changes or corrections may occur throughout the year.

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Introduction

The Uniform Medical Plan (UMP) July 1, 2005 Chiropractor Fee Schedule (most commonly billed services) contains the maximum allowances used to reimburse services provided by chiropractors. Please refer to the UMP *Certificate of Coverage* for plan benefit information and the UMP *Billing and Administrative Manual for Professional Providers* for billing instructions and payment policies.

The majority of the fee schedule is based on the Resource Based Relative Value Scale (RBRVS) methodology. The RBRVS maximum allowances are calculated using the Centers for Medicare & Medicaid Services (CMS) 2005 relative value units (RVUs); CMS statewide Geographic Practice Cost Indices (GPCIs) for Washington State; and the UMP conversion factor of $50.00.

CMS' 2005 RVUs were published in the November 15, 2004 Federal Register (Vol. 69, No. 219) and are also available on CMS' web site at cms.hhs.gov. The statewide GPCIs are: 1.003 (work), 1.017 (practice), and 0.819 (malpractice).

The RBRVS maximum allowances are determined by the following formula:

[(work RVU x work GPCI) +
(practice expense RVU x practice expense GPCI) +
(malpractice expense RVU x malpractice expense GPCI)]
x UMP RBRVS conversion factor

The UMP maximum allowances for the evaluation and management procedure codes are set at 90% of the full RBRVS amounts determined by the above formula.

Most other procedure codes not included in this publication when covered will be paid according to the maximum allowances in the UMP *Professional Provider Fee Schedule* or UMP *Prosthetics and Orthotics Fee Schedule.*

Please note: Some billed services and supplies may require medical records for UMP coverage decisions.

The UMP fee schedule uses Current Procedural Terminology (CPT™) and Healthcare Common Procedure Coding System (HCPCS). The descriptions for the CPT™ and HCPCS level II codes listed are abbreviated. For billing purposes, please use the most recent edition of the CPT™ and HCPCS level II coding books, which include complete descriptions of the codes.

Visit the UMP web site at www.ump.hca.wa.gov to download copies of all UMP publications mentioned in this document. If you have any questions, please call (206) 521-2023 (within the Seattle area) or toll free at 1-800-292-8092.

Fee Schedule for Most Commonly Billed Codes

The descriptions for the codes listed below are abbreviated. For billing purposes, please use the most recent edition of the CPT™ and HCPCS books, which include complete descriptions of the codes.

Chiropractic Manipulative Treatment (Spinal)

Code	Brief Description	Maximum Allowance
98940	Chiropractic manipulation	$34.50
98941	Chiropractic manipulation	$48.50
98942	Chiropractic manipulation	$63.00

Chiropractic Manipulative Treatment (Extraspinal)

Code	Brief Description	Maximum Allowance
98943	Chiropractic manipulation	$32.50

Multiple procedure rules are applicable when spinal and extraspinal manipulative treatment are provided on the same date of service. Report modifier -51 with CPT™ code 98943 in this circumstance.

It is inappropriate to report more than one unit in the units field on the claim for any of the chiropractic manipulation codes, unless a second office visit is medically necessary for additional manipulation treatment on the same date of service. If more than one visit is billed on the same date of service, medical records will be required.

Evaluation and Management Service - New Patient

Code	Brief Description	Maximum Allowance
99201	Office/outpatient visit, new	$43.65
99202	Office/outpatient visit, new	$77.85
99203	Office/outpatient visit, new	$115.65
99204	Office/outpatient visit, new	$163.35

Evaluation and Management Service - Established Patient

Code	Brief Description	Maximum Allowance
99211	Office/outpatient visit, est	$26.10
99212	Office/outpatient visit, est	$46.35
99213	Office/outpatient visit, est	$63.00
99214	Office/outpatient visit, est	$98.55

Fee Schedule for Most Commonly Billed Codes

Diagnostic Radiology

Code	Brief Description	Maximum Allowance
72010	X-ray exam of spine	$85.50
72020	X-ray exam of spine	$32.50
72040	X-ray exam of neck spine	$47.00
72070	X-ray exam of thoracic spine	$49.50
72100	X-ray exam of lower spine	$50.50
73030	X-ray exam of shoulder	$43.00
73080	X-ray exam of elbow	$42.50
73110	X-ray exam of wrist	$40.00
73510	X-ray exam of hip	$45.00
73560	X-ray exam of knee, 1 or 2	$39.00
73610	X-ray exam of ankle	$40.00

Physical Medicine and Rehabilitation

Code	Brief Description	Maximum Allowance
97010	Hot or cold packs therapy	Bundled Service (not separately payable)
97012	Mechanical traction therapy	$19.50
97110	Therapeutic exercises	$37.00
97112	Neuromuscular reeducation	$39.00
97140	Manual therapy	$35.00

Complementary and Preparatory Services

Patient education or complementary and preparatory services are not separately reimbursed. Complementary and preparatory services are defined by the UMP as interventions that are used to prepare a body region for or facilitate a response to a spinal or extremity manipulation/adjustment. For example, the application of heat or cold is considered a complementary and preparatory service that is not separately payable.

Payment Policy for Evaluation & Management (E&M) Services

UMP follows the CPT™ definitions for E&M services for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. (See CPT™ for complete code descriptions, definitions, and guidelines.)

Chiropractic physicians may report the first four levels of CPT™ new patient office visits codes (99201-99204) and the first four levels of CPT™ established patient office visit codes (99211-99214) for UMP payment consideration.

New Patient E&M Services (99201 - 99204)

A new patient E&M office visit code is payable only once within a three year period for chiropractic services. The usage of a modifier -22 will not be considered in the payment determination. New patient E&M office visit codes are payable with manipulation codes **only when all of the following conditions are met:**

- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the manipulation visit; and
- Modifier -25 is added to the new patient E&M code; and
- Supporting documentation describing the service(s) provided is included in the patient's record.

Established Patient E&M Services (99211-99214)

An established patient E&M office visit code is not payable on the same day as a new patient E&M office visit code for chiropractic services. The usage of a modifier -22 will not be considered in the payment determination. Established patient E&M codes are not payable in addition to manipulation codes for follow up visits except when all of the following conditions are met:

- The E&M service is for the **initial visit** for a **new condition or new injury;** and
- The E&M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the manipulation visit; and
- Modifier -25 is added to the E&M code; and
- Supporting documentation describing the service(s) provided is included in the patient's record.

When a patient requires re-evaluation for an existing condition or injury, either an established patient E&M CPT™ code (99211-99214) or a chiropractic manipulation (98940-98943) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Recordkeeping Guidelines

Uniform Medical Plan (UMP) requires that all chiropractic services eligible for reimbursement are medically necessary. To promote effective communications, UMP expects the following related to chiropractic recordkeeping.

Legibility: All treatment records must be both legible and understandable to a qualified reviewer. This includes legible handwriting as well as recognized abbreviations and terminology. The reviewer must be able to evaluate and follow the treatment plan as set forth and as it is revised over time as the condition warrants.

Standards: Clinical records or treatment notes should be consistent with the standards outlined in Washington licensure statutory code (WAC 246-808-560). A history should be taken that indicates patient status at the time of the initial visit or at the onset of the new condition. This documentation should encompass, but not be limited to, the following S.O.A.P. format and essential criteria.

S - Subjective Data
Treatment records should include a brief description of the patient's symptoms and complaints in his or her own words whenever possible. This should include improvements, exacerbations and changes since last visit. New conditions should be reflected in additional history. A subject statement from the patient should be recorded for each visit. One-word entries, such as better, worse, same, headache, or back pain are not sufficiently descriptive. Entries should reflect change over time, hopefully as a response to treatment, but reflecting changes as a result of the patient's daily or occupational activities, intervening injuries, and exacerbations. Descriptions should describe changes in frequency, intensity, location and radiation of pain.

O - Objective Data
In this section, treatment records should include objective findings. Initially, examination forms may be referred to. During subsequent visits, records should include changes in the initial, positive findings and any other new data that may be relevant. This section can include informal observations such as antalgic posture, as well as a more formalized reevaluation such as ranges of motion, orthopedic and neurologic tests, subluxations and muscle tone. Usually only a few critical indicators need to be repeated. Findings should be adequately qualified and quantified to facilitate assessment of progress and response to care over time.

A - Assessment
Each treatment should include a diagnostic impression or analysis of the information gathered during history and exam. On follow-up visits this should reflect changes in the subjective and objective data. Examples of clinical assessments include: subluxation resolving; cervical sprain exacerbating; or, radicular symptoms resolved. This section should also include possible differential diagnosis and / or other problematic conditions that may exist.

P - Procedures / Plan
The final section of the treatment record should include a description of the procedures employed that day. It should also include specific treatment delivered, patient instructions, orthotic prescriptions, rehabilitation and exercise instructions, and referral procedures. The plan portion of the record should include basic details related to ongoing treatment. For example: Three times per week for two weeks; then two times per week for two weeks; then reevaluate. There should also be an estimate of the total duration of time in which this condition is expected to resolve.